2009 Berkshire Hills Emanuel Camp *Required Form*

Camp Health Examination Form Part I

Name: ______________________________ Birthdate: ________ Sex: M/F Age: ____ (Circle one: Staff/Camper)
Address: ______________________________
Mother/Guardian: ______________________________ Email address______________________________
Home Phone____________________ Work Phone____________________ Cell Phone ____________________
Father/Guardian: ______________________________ Email address______________________________
Home Phone____________________ Work Phone____________________ Cell Phone____________________

Persons to contact if parent/guardian is unavailable:

1) Name______________________________ Relation to child __________ Home Phone____________________

Email address______________________________ Cell Phone ____________________

2) Name______________________________ Relation to child __________ Home Phone____________________

Email address______________________________ Cell Phone____________________

Health History: Explain yes answers and give dates

Has/Does the camper/staff: Yes/No *ALLERGIES*______________________________

1. Had any recent injury, illness or infectious diseases______________________________
2. Have a chronic or recurring illness/condition ______________________________
3. Ever been hospitalized ______________________________
4. Ever had surgery ______________________________
5. Have frequent headaches ______________________________
6. Ever had a head injury ______________________________
7. Ever have loss of consciousness ______________________________
8. Wear glasses, contacts or protective eye wear ______________________________
9. Ever had frequent ear infections ______________________________
10. Ever had seizures ______________________________
11. Ever have dizziness during exercise ______________________________
12. Ever diagnosed with a heart murmur ______________________________
13. Ever diagnosed with heart arrhythmias ______________________________
14. Ever had back problems ______________________________
15. Ever had joint problems/injuries ______________________________
16. Have an orthodontic appliance ______________________________
17. Wear braces ______________________________
18. Have any skin problems/ailments ______________________________
19. Have diabetes ______________________________
20. Have asthma ______________________________
21. Had mononucleosis in past 12 months ______________________________
22. Had problems with diarrhea/constipation ______________________________
23. Have problems sleepwalking ______________________________
24. Had lice infestation (when) ______________________________
25. Have an abnormal menstrual history (If female) ______________________________
26. Have ADD/ADHD ______________________________
27. Have OCD/ODD ______________________________
28. Ever have Lymes disease (when) ______________________________

PLEASE ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD

This health history is correct and complete as far as I know. I hereby give permission for Berkshire Hills Emanuel Camp's Medical staff to provide routine health care, administer prescribed and over the counter medications, and seek emergency and/or surgical treatment for said camper/staff. All bills for physician's care, dental care, hospital visits, laboratory tests, x-rays and prescription medication will be sent directly to the family for submission to its insurance plan.

Signature of Parent or Guardian______________________________

Date______________________________

PARENTAL/GUARDIAN MEDICAL AUTHORIZATION FORMS

Name____ (circle one: Camper/Staff)
I hereby give permission to Berkshire Hills Emanuel Camp to provide routine health care, administer prescribed and over the counter medications, and seek emergency treatment including ordering x –rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to Berkshire Hills Emanuel Camp to arrange necessary related transportation for me/my child.
In the event I or my designated substitutes cannot be reached in an emergency, I hereby give permission to Berkshire Hills Emanuel Camp to obtain institute and medical care including hospitalization, for the person named above. This authorization form can be photocopied for trips out of camp.

MENINGOCOCCAL MENINGITIS VACINATION RESPONSE FORM (FOR NEW CAMPERS ONLY)

New York State Public Health Law requires the operator of an overnight children's camp to maintain a completed response form for every camper who attends camp for 7 or more nights.
(Note the vaccine's protection lasts for approximately 3 to 5 years. Revaccination may be considered within 3-5 years).

Camper's Name: __________________________ Date of Birth: ____________

Check one box only and sign below.
( ) My child has had the meningococcal meningitis immunization (Menomune) within the past 10 years.
Date received________

( ) I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against the disease.

MEDICAL AUTHORIZATION

To comply with HIPPA: I _______________________, parent or guardian of ____________________ authorize any physician, nurse or other health care provider, to communicate with the medical staff and director of Camp, or his/her designee, about my child's medical condition, treatment and prognosis.
We further authorize the camp medical staff to discuss any medical conditions with the director, his/her designee, or the child's counselor when the medical staff, in its sole discretion, believes such communication to be in the best interest of the child. ***These authorizations are limited to June 2009 through August 2009***

Signature of Parent/Guardian____

Print Name __________________________________ Date____________________

Signature recognizes agreement with all of the above documentation

2009 Berkshire Hills Emanuel Camp *Required Form*
Camp Health Examination Form Part II

TO BE COMPLETED BY HEALTH CARE PROVIDER

Name: ______________________________________ Age: _________ Weight: _______ Height: _________

ALLERGIES: (If none Please document – NONE) ____
____

____

PHYSICAL EXAMINATION

BP________ HR_______ RR______ Vision OD 20/_____ OS 20/_____
Head __________________________ Ears________________________ Eyes____________________
Nose__________________________ Throat________________________ Scalp____________________
Muscular/Skeletal__________________________ Respiratory __________________
Cardiovascular ______________ Neurological __________________________
Liver __________________________ Spleen __________________
Gastrointestinal __________________________ Gastrourinary ________________
Genitalia _____________________________
(For Females) Has menstruation begun/ has menstruation normal ____________________________
Other illnesses or surgeries ____
Please briefly describe any pertinent positives: ____
____

Immunization History

Polio: #1_____ #2 _____ #3_____ #4_____ DTaP: #1_____ #2 ______ #3 ______ #5_____

MMR: #1____ #2____ HBV: #1_____ #2 ____ #3_____ HiB: _______ HPV: #1____#2____ #3______

Varicella: __________ Meningococcal vaccine: _______

Had camper/staff have: Measles ____ Chicken Pox ____ German Measles ____ Mumps ____

Hepatitis A ____ Hepatitis B ____ Hepatitis C ____

***Continues on back**

TB Mantoux Test (PPD): Date of last test________ Results________

Limitations to activities: Swimming____ Diving ____ Hiking ____ Athletics ____ Other ____
Please explain above: ____

____

I certify that I have on this date examined the above named camper/staff and that on the basis of my examination and the medical history as furnished to me, I have found no reason which would make it medically inadvisable for this camper/staff to participate in physically strenuous activities. It is my opinion that this person is physically able to engage in all camp activities

Licensed Physician's Signature________________________________

Licensed Independent Practitioner Signature (if examined by other than an MD) ______________________

Address____ License#______________________________

Telephone Number____ Date___________________________

2009 Berkshire Hills Emanuel Camp *Required Form*

INDIVIDUAL MEDICATION ORDERS

**** THIS FORM MUST BE SIGNED BY HEALTH CARE PROVIDER (MD;NP;PA) AND PARENT/GUARDIAN****
****THIS FORM MUST BE SIGNED AND FILLED OUT EVEN IF CAMPER/STAFF IS NOT ON PRESCRIBED MEDICATION****
WITH FEW EXCEPTIONS NO PRESCRIPTION OR OVER THE COUNTER MEDICATIONS ARE TO REMAIN WITHIN CAMPER/STAFF POSSESSION. ALL MEDICATION MUST BE KEPT IN THE INFIRMARY
PLEASE PRINT NEATLY

Name____ Birthdate_____________________ Camper/Staff (circle one)

Allergies (if any) ____

____

****MEDICATIONS ARE GIVEN AT MEALTIMES AND BEFORE BED****
Prescription Medications (Including Vitamins) – Document "none" if not on any

Name of Medication **Dosage (amount taken)** **Frequency (how many times/day – when)**

1) ____

2) ____

3) ____

4) ____

5) ____

6) ____

PLEASE USE OTHER SIDE OF FORM TO LIST ADDITIONAL MEDICATIONS /VITAMINS OR FOR NOTES

STANDARD OVER THE COUNTER/PRN (AS NEEDED) MEDICATIONS
WILL BE ADMINISTERED AS PER LABEL BY AGE/WIEGHT

(Circle Response)

Acetaminophen (Tylenol) Yes/No Ibuprofen (Motrin/Advil) Yes/No Pseudophed Yes/No

Cough Suppressants Yes/No Antacids Yes/No Dramamine Yes/No

Decongestants Yes/No Antihistamines (Benadryl) Yes/No Anti-diarrhials Yes/No

Topical Antibiotics (bacitracin/neosporin/bactroban) Yes/No

Topical Antipruritics (hydrocortisone/calamine/Benadryl) Yes/no

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BOTH HEALTH CARE PROVIDER (MD;NP/PA) AND PARENT/GUARDIAN SIGNATURE NEEDED

SIGNATURE OF MD/NP/PA___________________________ SIGNATURE OF PARENT/GUARDIAN_________________
LICENSE NUMBER ____ DATE____
STAMP: